June 6, 2002

The Honorable Bill Thomas
Chairman
House Ways and Means Committee
2208 Rayburn House Office Building
Washington, DC 20515

Honorable Nancy L. Johnson
Chairwoman
Health Subcommittee, Ways and Means
2113 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Thomas and Chairwoman Johnson,

The Visiting Nurse Associations of America (VNAA) supports the House Ways and Means Committee's Medicare reform legislation and its House passage. We are particularly grateful for the provision to repeal the 15% cut and a provision to extend the 10% add-on to reimbursement for home health services delivered to beneficiaries in rural areas. We are more than pleased that you have been supportive in light of the recent GAO report.

As we have mentioned in earlier correspondence to you, the GAO report was based on fiscal year 1997 cost data trended forward and did not consider the effects that IPS had on decreased utilization nor the effects of PPS on increased regulatory costs. Not only did the report not consider the adverse effects of IPS, but wrongly attributed the decreased utilization to PPS rather than IPS. The GAO report does not at all reflect the experience of VNAs under PPS.

The repeal of the 15% cut and the 10% extension of the rural add-on will bring badly needed stability to Visiting Nurse Agencies (VNAs) and their ability to be the safety-net providers in their communities. We believe that PPS is generally very successful because it creates appropriate incentives for efficiency, is case-mix adjusted, and is appropriately monitored for quality of care through outcomes-based data collected by the Centers for Medicare and Medicaid Services (CMS). Because VNAs are, on average, losing money from Medicaid, managed care and charity care, any size cut to Medicare now (whether 5% or 15%) would create overall negative bottom lines and destabilize the viability of our members.

VNAA is more than grateful for your continual support for VNAs and openness to our concerns. We regret that our action call on the copay issue may have led you to believe that we are not grateful for your efforts.

We are supportive of your legislation and, at the same time, continue to have concerns about the proposed beneficiary copayment. While the $40 per episode amount is not substantial to individuals with steady income, we fear that it will be substantial to those on fixed income who are not eligible for Medicaid or the QMB allowance. Our experience with a Medicare copay in the past leads us to believe that many patients near poverty level will not accept the care because they would have to forgo something else

vital to their well being to receive the care, such as sufficient amounts of food or paying for their utilities. We hope that we can discuss with you means to protect the population that is not poor enough for Medicaid but, nevertheless, poor and vulnerable to cost-sharing.

Chairman Thomas and Chairwoman Johnson, we hope that you will also consider including a stronger provision in your bill concerning OASIS – the home health patient assessment form – that would make optional the collection of OASIS data from non-Medicare patients and is budget neutral. The bottom line reason for limiting OASIS to only Medicare patients is that federal regulatory paperwork (OASIS being the largest component of the paperwork) has become such a burden on nurses that is driving many VNA nurses out of the profession.

Nurses spend an average 2.5 hours during an admission visit in a patient's home. Seventy percent of this time is spent filling out and explaining federal paperwork. Home health nurses are leaving for more clinically-focused jobs and leaving the existing nurses on staff more stressed, which then creates a bigger problem in trying to retain the remaining nurses and recruit new nurses. During this time of a national nursing shortage, VNAs have average 15% nurse vacancy rates and find it difficult to recruit new nurses because of the long hours and oppressive paperwork.

CMS Administrator Thomas Scully recently met with several home health providers and personally reviewed all of the OASIS items. He repeatedly said that the federal government shouldn't be requiring such extensive information collection from patients (an 80+ question survey). He has directed his staff to limit the number of questions to those that are absolutely necessary. CMS career staff have informed him that only Congress can change the current requirement to collect OASIS data from all patients receiving skilled care because the Medicare statute, while not addressing OASIS specifically, requires patient assessment forms to ensure quality of care for all patients. The Medicare conditions of participation for home health care specify that OASIS should be the instrument to ensure quality for all patients.

We believe that the policy of requiring OASIS for all patients does not comport with CMS' goal to move home care oversight from the current process-driven orientation to an outcome-driven orientation. We believe that collecting OASIS data from only Medicare patients (and measuring their outcomes) is likely to be the best and most efficient process for determining an agency's overall level of quality care because it is a clean set of data from a more homogenous patient population. If an agency consistently achieves good outcomes for its Medicare case load, it would be highly unlikely that the same agency would provide less quality care to its non-Medicare patients (especially in light of requirements to comply with all other Medicare conditions of participation for all patients.)

Chairman Thomas and Chairwoman Johnson, we ask you to please include in your Medicare reform bill a provision to limit OASIS to only Medicare patients, or at least, include a provision that the Senate Finance Committee included in its Medicare

regulatory reform bill, S. 1723, that suspends OASIS data collection from non-Medicare patients while the Secretary reviews the appropriateness of collecting it on all patients during an 18-month period, to be followed by a recommendation by the Secretary to Congress.

Finally, we have a very personal request to include another provision that should be of minimal cost. There is a man by the name of David Jayne who is dying of ALS - Lou Gehrig's disease -- who has a simple wish before he dies to change the homebound statute ONLY for the purpose of allowing individuals like him, who have a severe and permanent disability and who are already eligible for Medicare home health services, to leave their homes without losing their home health benefits.

Former Senator Bob Dole is chairman of Mr. Jayne's coalition - the National Coalition to Amend the Medicare Homebound Restriction - and has vowed to fight for David so that he can see this legislation pass in David's life time. While the legislation that has already been introduced by Senators Susan Collins (R-ME) and Congressman Edward Markey (D-MA) (S. 2085 and H.R. 1490, respectively) would probably not receive a score by CBO that would enable its inclusion in your bill, we have worked out a narrower version of the legislation that has received CMS's Tom Hoyer's support.

The legislation would only affect those individuals currently eligible for home health care who have permanent and severe disabilities that a physician believes will persist for one year or longer, and which require personal or technical assistance to leave the home. This provision simply gives these individuals freedom to be active participants in their communities without fear of losing their home health services. As Senator Dole said during a recent press conference, "I don't think they're going to go out and steal third base." We've attached the legislative language for the narrower version of S. 2085 and H.R. 1490 for your consideration.

Thank you very much for all of you have done for home health care this year. We very much look forward to our meeting with you tomorrow.

Sincerely,

Kathy Thompson
Vice President, Legislative and Public Affairs
VNAA

Cc: Mary Lou Stricklin, Chair, VNAA Board of Directors
Carolyn Markey, President and CEO, VNAA